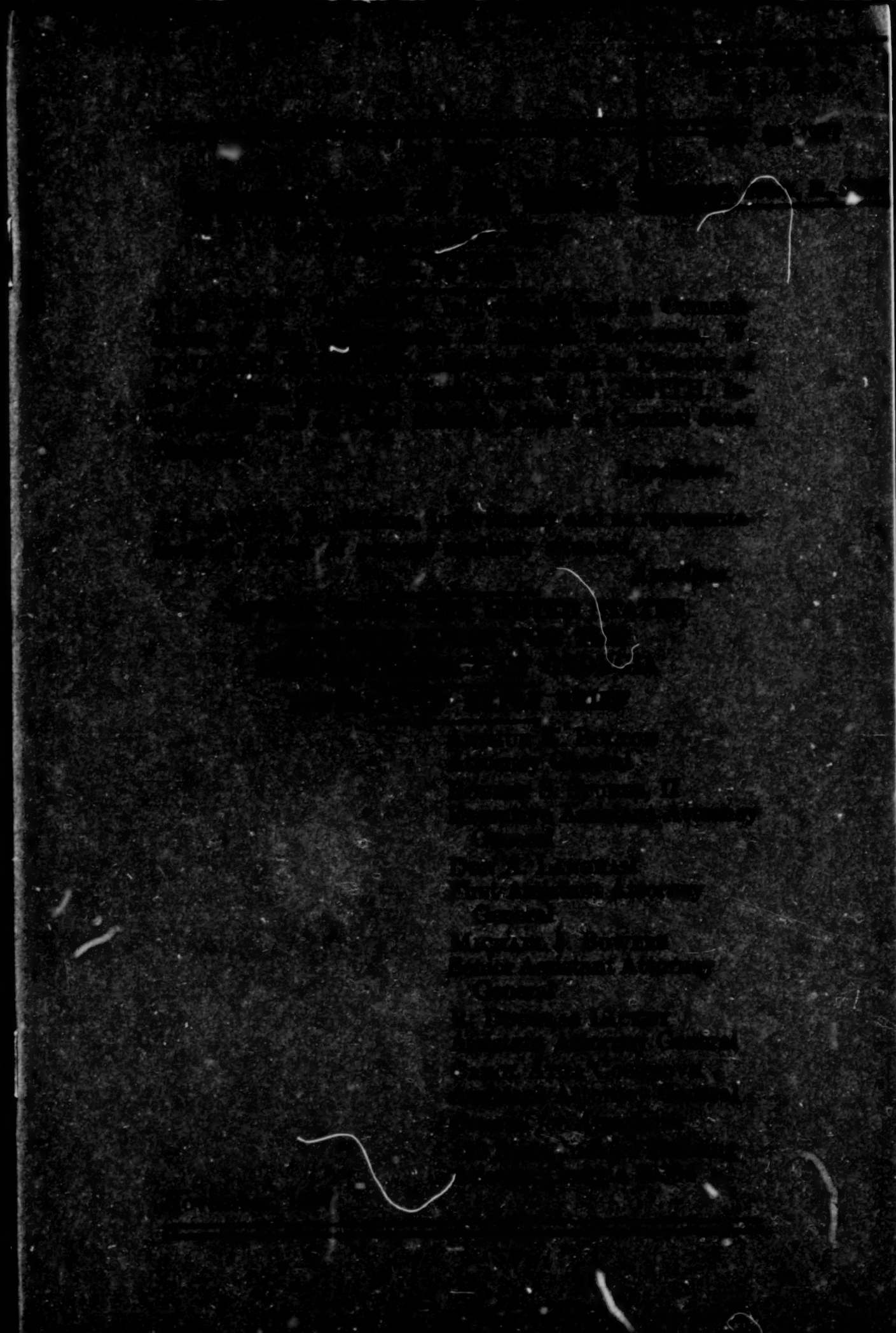

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IN THE

Supreme Court of the United States

October Term, 1977

No. 75-1690

T. M. "JIM" PARHAM, Individually and as Commissioner of the Department of Human Resources, W. DOUGLAS SKELTON, Individually and as Director of the Division of Mental Health and W. T. SMITH, Individually and as Chief Medical Officer of Central State Hospital,

Appellants,

v.

J. L. and J. R., Minors, Individually and as representatives of a class of persons similarly situated,

Appellees.

APPEAL FROM THE UNITED STATES DISTRICT COURT FOR THE MIDDLE DISTRICT OF GEORGIA

APPELLANTS' REPLY BRIEF

This brief is presented for the purpose of (1) identifying material issues which the Appellees have failed to address and (2) insuring that the framework within which this case is presented to the Court is as objective as it should be.

Specifically, with the exception of the United States, neither the Appellees nor *amici curiae* have directly ad-

dressed the critical issue of whether the "interest" sought to be protected in this litigation, the right of a child to refuse to accept medically-indicated treatment selected for the child by his parents, has a constitutional dimension.

Moreover, the analytical framework relied upon almost exclusively by the Appellees and *amici curiae* to support their position is predicated upon a parade of horribles. That is, their positions are supported in large part by generalizations which have been developed from historical sources or experiences in states other than Georgia, many of which bear no relation to the current provision of mental health care in Georgia, and most of which are directly contradicted by the evidence in the record.

This case is far too important to the children and parents who will be affected by this litigation to allow these matters to pass without comment.

A. THE APPELLEES AND *AMICI CURIAE* HAVE AVOIDED THE ISSUE OF WHETHER A CONSTITUTIONALLY PROTECTED INTEREST IS INVOLVED IN THIS LITIGATION.

The threshold issue in any case involving the alleged deprivation of a constitutional right to due process is whether the "interest" sought to be protected falls within the ambit of the Fourteenth Amendment to the Constitution of the United States.

This proposition was succinctly stated in *Smith v. Organization of Foster Families for Equality and Reform*, ——— U.S. ———, 97 S.Ct. 2094 (1977), where this Court, citing *Board of Regents v. Roth*, 408 U.S. 564 (1972), said:

> "The District Court decided that procedural due process guarantees apply in this case *by assessing and balancing* the particular interest involved . . . . [A]

> weighing process has long been a part of any determination of the form of hearing required in particular situations by procedural due process. *But, to determine whether due process requirements apply in the first place, we must look not to the 'weight' but to the nature of the interest at stake. . . . We must look to see if the interest is in the Fourteenth Amendment's protection of liberty and property.*" *Id.* at 570-571. [Emphasis added]

The "interest" involved in this litigation is the interest a child has in contesting a decision by his parents or guardian as to the desirability or necessity of medically-indicated treatment. We submit that medically-indicated decisions of parents and guardians, even though those decisions may ultimately result in the deprivation of the child's life or liberty, are routinely and properly left to the parents and the physicians whose advice they elicit and do not implicate any constitutional provisions which would require due process.

Only the United States acknowledges that this is an independent key issue which must be resolved before any "weighing" or "balancing" may be done. (Brief of United States, p. 23) However, even though recognizing that issue, the United States immediately joins Appellees and the other *amici curiae* who would resolve the threshold issue of whether a child may constitutionally refuse to accept treatment elected by his parents by looking to the risk of injury, the nature of the injury, and the deprivations that may flow therefrom.

This *ad hoc* determination of the existence of a constitutional right, however, is simply not consistent with this Court's prior decisions. Either the child has a constitutional right to refuse to accept medically-indicated treatment selected by his parents, in which case it will be proper

to "weigh" and "balance" the injuries which may flow from such a decision in order to determine "what process is due" to the child, or, in the alternative, the child has no such constitutional right, in which case this litigation must end.

The Appellants believe that utilizing the Appellees' and *amici curiae's* analysis has the effect of placing the cart before the horse. Under the analysis of the Appellees and *amici curiae*, whenever there is a possibility of an injury resulting from a parental decision, which, assuming State action, arguably could be brought within the protection of the Fourteenth Amendment to the Constitution, a constitutional right would spring into existence, a right which would allow the child to challenge that decision. The constitutional right thus created is not the result of any independent right that the child might have to contest his parents' decision, but arises solely from the potential for injury that flows from that decision. Thus, the Appellees and *amici curiae*, by following procedures normally utilized to determine "what process is due," have bootstrapped the children into a position where they could have a constitutional right which would not otherwise exist in the absence of potentially grievous injury to the child.

The factual situation in which this case arises tends to divert attention from the gap in the Appellees' reasoning. The following illustration should illuminate the weakness of the Appellees' and *amici curiae's* arguments.

Suppose a parent brings his child to a State-employed physician who works in a State-owned and operated hospital. The physician, after examining the child, determines that the child is exhibiting symptoms of a form of cancer, the treatment of which would involve the removal

of one of the child's legs. The parents are faced with the decision of whether to authorize the surgery.

Obviously, one consequence of the decision to authorize the surgery is that the child will lose his leg. This loss is a necessary result of the treatment for the illness from which, the doctor believes, the child suffers.

Clearly, if confinement and physical restraints constitute a "massive curtailment of liberty," the deprivation of one of the members of a child's body could constitute no less of a curtailment. Under the Appellees' and *amici curiae's* analysis, because the parental decision could result in a deprivation of the child's liberty, the original decision can only be made in a constitutionally permissible manner. That is, because the deprivation which flows from the decision results in an infringement on a constitutionally protected interest, the child is thereby given a constitutional right to challenge the original decision.

Of course, no one has argued that the child has a constitutional right to refuse this treatment, in spite of the severe consequences of the surgery. Indeed, the United States admits as much,[1] saying that it would be unprecedented to require due process in such a situation and that there is no case law which would support such a conclusion.

More to the point, it is clear that no one has argued that a child has a basic constitutional right to refuse medically-indicated treatment in all cases. Instead, the Appellees and *amici curiae* assert that this right exists in some cases, i.e., decisions involving the treatment of mental illness. Thus, they assert that a constitutional right exists not in all instances, but in only a few, depend-

[1] Brief of the United States, p. 23, note 25.

ing on the type of risk, and the injury that follows from taking the risk.

This would indeed be a unique and novel way to determine what rights flow from our Constitution and would require a complete reworking of this Court's opinions as to whether a constitutionally protected interest exists.

The better and more consistent course is to continue, as this Court has in the past, to examine the "interest" asserted to determine whether it is constitutionally protected, rather than "weighing" and "balancing" the potential results of an infringement upon that "interest" before determining if it is of constitutional dimension. Such an examination demonstrates, as Appellants assert in their main brief, that a child has no constitutional right to contest his parents' decision as to the necessity of medically-indicated treatment.

B. CHILDREN IN GEORGIA ADMITTED TO MENTAL HEALTH FACILITIES ARE NOT STIGMATIZED BY SUCH ADMISSION.

Appellees and *amici curiae* have asserted that children are invariably stigmatized by their admission to a State mental health facility, and that their interest in avoiding this stigmatization is sufficient ground to require the full panoply of due process rights.

The first answer to this assertion is to point out that the district court did not find in fact that any of the children in this case were actually stigmatized by hospitalization. Moreover, Appellees have pointed to no evidence in the record that the stigmatization of a mentally ill child who is institutionalized for a short period is greater than the stigmatization of a mentally ill child who receives non-institutional treatment. Finally, even if hospitalization

were important in and of itself, stigma can arise only if people are told that the child has been in the hospital. This explains the legal requirement that a person bringing a cause of action for deprivation of liberty due to stigmatization allege and prove that the stigmatizing information is published and disseminated by the defendant.

In *Bishop v. Wood*, 426 U.S. 341 (1976), a discharged police officer complained of stigmatization due to inaccurate charges of insubordination, "causing low morale" and "conduct unsuited to an officer." This Court assumed that the officer's discharge was a mistake and based on inaccurate information. However, this Court held that:

> "Since the . . . communication was not made public, it cannot fully form the basis for a claim that petitioner's interest in his 'good name, reputation, honesty or integrity' was thereby impaired." *Id.* at 348.

While Justice Brennan in his dissent argued that the information would inevitably be disclosed because the officer was "in a profession in which prospective employees are invariably investigated [and] petitioner's job prospects will be severely restricted by the governmental action in this case," the majority of this Court clearly required actual publication of the stigmatizing information before deprivation of a liberty interest could be established.

There is absolutely no evidence before this Court that the State of Georgia has or will ever publish any information which would indicate that any plaintiff had ever been admitted to a State mental health facility. In fact, the Georgia Code specifically makes the patient's clinical record a confidential document[2] and prohibits disclosure

[2] Georgia Code § 88-502.10 provides in pertinent part:

> "*Confidentiality.*—(a) A clinical record for each patient shall be maintained. The record shall include data pertaining to admis-

except in very limited circumstances. Even during the litigation in this case, the identity of the plaintiffs has been concealed to the greatest extent possible, with the major disclosure of the identity of the plaintiffs occurring only after the district court unsealed the depositions taken in the case and allowed the news media to review them, a disclosure which the district court later attempted to cure by ordering that all persons having knowledge of the identity of the plaintiffs not disclose such information.[3]

Thus, while the Appellees and *amici curiae* may generalize about the stigmatization flowing from the admission of a child to a State mental health facility, the record in this case clearly demonstrates that there is no publication of that information, and thus, references to patients' inability to obtain jobs, and similar assertions,[4] are entirely inappropriate and provide no basis for the existence of any constitutionally protected interest.

C. THE APPELLEES' AND *AMICI CURIAE'S* LEGAL THEORIES AND CONTENTIONS ARE PREDICATED UPON GENERALIZATIONS NOT APPLICABLE TO THE MATTER BEFORE THE COURT.

Appellees and *amici curiae* have tended to focus on broad generalizations rather than on the facts in the rec-

sion and such other information as may be required under regulations of the department. Unless waived by the patient or guardian and his attorney, the privileged and confidential status of all information given such status by section 38-418(5) shall not be lost by either authorized or unauthorized disclosure of such information to any person, organization or agency. The clinical record shall not be a public record and no part of it shall be released [except in specific enumerated cases]." [Bracketed matter added].

[3] Order of District Court entered December 19, 1975.

[4] Appellees' Brief at 32-33.

ord. This erroneous approach to this case is of great concern to Appellants, who designed their admissions procedures, programs of treatment and the other aspects of their mental health care efforts with a view to what presently exists in Georgia, not with a view to what formerly existed in Georgia or what may exist elsewhere.

Appellants believe that it is necessary to correct the record on the parade of horribles relied upon by Appellees and various of the *amici curiae*.

1. The record refutes Appellees' generalization that State mental health facilities in Georgia are overcrowded, under-financed or under-staffed.

The briefs of the Appellees and *amici curiae* assert again and again that State mental health patients are placed in deplorable, decrepit facilities which are overcrowded, under-financed and under-staffed. One brief actually declares:

> "The snake-pit conditions of most of our mental hospitals are so wide-spread as to have reached almost universal recognition." [5]

The Appellees attempt to capitalize on this type of generalization by noting that at one time the State mental health facility in Milledgeville, Georgia, was the largest mental hospital in the world, with 12,000 patients.[6] Appellees then assert, in the same paragraph, that the present population of that same facility is 7,523 patients, and cite as authority the district court's opinion.[7]

However, the Appellees, in their zeal to suggest that terrible conditions exist in the State mental health facilities, misread both the district court's order and the evi-

[5] Brief of the Child Welfare League, at p. 25.

[6] Appellees' Brief at 24.

[7] *Id.*

dence. The district court stated, correctly, that there were 7,523 patients, but this included both the mentally ill and the mentally retarded, *throughout the entire State-wide system, including all eight regional hospitals as well as several institutions for the mentally retarded.* The district court did not find, the evidence does not demonstrate, and it is not true that there were over 7,000 patients in any one facility.

Moreover, the evidence presented to the district court did not demonstrate any current over-crowding or decrepit conditions in these State facilities. Dr. Messinger, the Appellees' expert witness, testified that while he was not happy about the physical facilities of the adolescent unit located at Central State Hospital, that he was "favorably impressed by the children's unit." Even with respect to the adolescent unit, Dr. Messinger did not testify that it was decrepit, over-crowded or under-staffed. He did say, in regard to the adolescent ward, that:

> "It was dismal, clean; the personnel seemed concerned and knowledgeable about, you know, their roles in the ward, but it truly was dreary." A-187.

Finally, as the record clearly indicates, the three members of the district court visited two of the State mental health facilities involved in this case. It is apparent from a reading of the opinion of the district court that it was not engaged in any kind of white-wash; had the court found bad conditions they would have been described in the opinion. However, the district court did not say that the judges found the facilities to be over-crowded or understaffed. Nor did the district court find the facilities to be "deplorable" or "decrepit," or a "snake-pit," or anything remotely like the assertions of Appellees and *amici curiae.*

The court did, of course, include findings which Appellees fail to mention about the financing of the menta

health program in the State of Georgia. The court specifically found that during fiscal year 1976, a total of $149,971,859.00 was appropriated directly for the provision of mental health care in the State of Georgia. As the court's figures demonstrated, almost one-third of the entire budget appropriated to the Department of Human Resources in the State of Georgia, the agency generally responsible for the provision of welfare services to the State's citizens, was earmarked specifically for mental health services. Moreover, using the district court's figures again, it is evident that the amount appropriated for the direct provision of mental health care in Georgia was almost 7% of the entire State budget during that fiscal year. While adequacy of financing is obviously a subjective concept, it is apparent that a substantial amount of the annual appropriations of the State of Georgia are spent for the provision of mental health care.

2. The absence of parents ready, willing and able to again accept their child after admission to a State mental health facility is not "a normal situation."

In an attempt to demonstrate an alleged conflict between parents and their children, the Appellees and several *amici curiae* relied upon the district court's generalization that:

> "The absence of parents ready, willing and able to again accept their child, is unfortunately a normal situation." 412 F. Supp. at 135.

The Appellees cite this generalization as a fact in their Statement of the Case.[8] Moreover, the Appellees attempt to support the district court's generalization by quoting the testimony of Dr. Everett Kuglar, the Superintendent of the Georgia Regional Hospital in Augusta, as follows:

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[8] Appellees' Brief at p. 4.

"The big problem is very often not getting the child well enough to go home, but getting the parents essentially, you know, [to] even take this child."[9]

The Appellees suggest, based on these "facts" that parents cannot be trusted to make correct decisions for their children. A closer look, however, shows that the situation is not as Appellees have portrayed it.

The district court's comment that parents are unwilling to accept their children after admission to a mental health facility was predicated specifically upon the testimony of Dr. James B. Craig, the Superintendent of the Georgia Regional Hospital at Savannah, who, according to the district court's opinion, testified that:

"Yes, you always have a few of these [parents who are reluctant to take their children out of a hospital after the staff recommends the discharge] because with the kinds of, say, cases you get admitted to a hospital, meaning that many times it's because of their disinterest and inability to get along when the child gets sick." 412 F. Supp. at 135. [Bracketed material in original].

Dr. Craig stated in his deposition, as did several other superintendents, that he was merely guessing at the number of children whose parents might be reluctant to take their child back [A-530], but in any event, the word Dr. Craig used was "few," not "normal."

The quote taken from Dr. Kuglar's testimony, considered in context, does not support the principle for which it was advanced; the full paragraph from which the quote was taken appears as follows:

"No. I don't see how it [the problem of parents running away] would be present during the admission process. Very often what has occurred here, is

[9] Appellees' Brief at p. 30, note 32.

that the child is brought to the hospital sometimes, by the judicial process, through the court system, and the parents feel like they didn't have any part in the admitting of this child to the hospital and aren't going to have anything to do with it. There often—is an amount of hostility and antagonism between them and the child which has reached the point where they don't want to accept this child, and *the big problem is very often not getting the child well enough to go home, but getting these parents to essentially, you know, to take this child.* And on one or two occasions we had to go back into the Court or through D.F.C.S. [County Department of Family and Children Services] to get a disposition made. There haven't been a lot of these, but they do occur. I don't see any sense, you know, I'm not trying to hide that sort of thing does occur." A-578-579. [Appellees' quotation italicized]. [Bracketed matter added].

Taken in context, the statement by Dr. Kuglar clearly indicates that the problem with parents refusing or being reluctant to take their children back arises primarily when the child has been brought into the hospital through the court system. This is especially important because Appellees ask for more court participation in the admission process. Thus, it is likely that ordering more court hearings would exacerbate whatever problem now exists.

More in point is Dr. Kuglar's testimony when he was specifically questioned about cases where parents were reluctant to take children back home after the hospital had recommended discharge. In response to the question about the frequency of this occurring, Dr. Kuglar responded as follows:

"Upon rare occasions we do. I'm sure we could recall a—two or three or four episodes during the last three or four years where this was a problem, but it's rarely a problem." A-561.

Using the worst combination referred to by Dr. Kuglar, four episodes of parental reluctance during the previous three year period, would result in a parental abdication in only four instances out of 299 actual discharges.[10]

Thus, while Appellees assert that parents normally refuse to take their children back after they have been admitted to a State mental health facility, the specific facts in the record contradict this generalization.

3. The average length of hospitalization is far shorter than the period alleged by the Appellees.

The Appellees interject into their argument the alleged fact that:

> "The average length of confinement for the class as a whole was 248.6 days, and at Milledgeville it was 456 days." [11]

The class that has been certified includes all those children who were in the hospital at the time the suit began, as well as "all persons younger than 18 years of age . . . hereinafter received by any defendant for observation and diagnosis. . . ." Opinion of the District Court,

[10] A-856.

[11] Appellees' brief at p. 32. The Appellants have been unable to determine how this figure was derived, since it is at variance with the figure stated by the district court in its opinion. The distinction between the two, to the extent that the Appellees' figure is based on the district court's opinion, is probably irrelevant since the district court's figures are also obviously in error. For example, the district court's opinion notes that the maximum time of confinement for any member of the plaintiffs' class at Central State Hospital on October 31, 1975 was 2,035 days. J.L., who had been there the longest, had been admitted on May 18, 1970, an interval of 1,992 days, not 2,035, even if leave from the hospital is ignored. Similarly, the court's opinion indicated that the minimum time of confinement for any member of the class then in Central State Hospital was 22 days. The record clearly shows that on October 31, 1975, the minimum time of confinement for any class member was 14 days, not 22. Similar discrepancies exist with the rest of the figures.

412 F. Supp. at 117. Thus, the relevant statistic is the period of hospitalization that a child in the class could anticipate. This being the case, it is grossly misleading to consider only the average period of hospitalization of those children who were in the hospital at the beginning of the litigation. A more descriptive figure is obtained by considering the length of hospitalization of all those children who have been admitted under the challenged Code section. Even this figure is somewhat overstated, since it is skewed by the handful of children who have been in the hospital for extended periods.

An analysis of the data in the record, including the duration of hospitalization for the previously discharged children, demonstrates that the median stay for all children hospitalized under the challenged Code section is less than 56 days. The mean or average stay for all of these children, including the named plaintiffs as well as the three or four other children who had been in the hospital for long periods, is only slightly over 142 days.[12]

Moreover, the same statistics demonstrate that of the 2,003 children voluntarily admitted to the hospital under the challenged Code section and subsequently discharged, 197 were discharged during the first 7 days of their hospitalization, an additional 178 were discharged during the next 7 days, another 317 were discharged during the next 15 days and over 1,300 were discharged in the first three months.

These figures, all of which are derived from the record, are certainly more descriptive than Appellees' characterization of "average lengths of confinement." Appellees' case is built on the adverse consequences of prolonged

[12] These figures were developed from the data found on pages A-824-887, using standard statistical analysis techniques and assumptions.

institutionalization. It is therefore important to note that most children are not institutionalized for extended periods, that most of the children in the hospital need to be there, and that Appellees overstate the average stay by nearly 75%.

4. The evidence in the record does not support the view that State psychiatrists tend to institutionalize persons unnecessarily.

Appellees and various of the *amici curiae* ascribe to the view that State psychiatrists tend to institutionalize persons unnecessarily. For example:

> "The tendency of mental health professionals to prescribe institutionalization for persons not in need of confinement has been widely noted. Various empirical studies have verified it." [Footnotes omitted].[13]

> "Empirical studies have demonstrated that psychiatrists and physicians employed by State mental institutions, recommend institutionalization of persons not in need of confinement." [Footnote omitted].[14]

With these generalizations Appellees and *amici curiae* attempt to establish the existence of a substantial risk of erroneous institutionalization of a child who either is not mentally ill or is not suitable for treatment in a mental health facility. However, these generalizations are substantiated neither by the record, nor, for the most part, by the studies cited by the Appellees and *amici curiae*.

First, the record clearly demonstrates that the State of Georgia has an extensive community mental health program, as well as the in-patient program which is the subject of this litigation. The district court itself noted that in fiscal year 1974, 5,596 children were treated as out-

[13] Brief of American Orthopsychiatric Association, et al., at pp. 33-34.
[14] Appellees' Brief at p. 44.

patients and only 515 were treated as voluntary in-patients. While this, of course, does not establish the appropriateness of the hospitalization of any of the 515 children, it does indicate that the State has non-hospital resources, and makes extensive use of them.

No comprehensive statistics were developed at the trial of this case to determine the number of prospective hospital patients who, throughout the system, are turned away and denied admission to the hospital, although there is an indication in the record that this happens frequently. For instance, Exhibit 9 to the deposition of Dr. Donald G. Miles, Superintendent of the Georgia Mental Health Institute in Atlanta, demonstrates that between July 1, 1967 and June 30, 1971, (the period during which the hospital was doing its own initial screening rather than having patients screened through community health centers), 635 applications for admission were received. Of these, 170 were cancelled and nearly 50% of the remaining children for whom admission was sought were rejected.

Of course, the question of whether a particular child should be admitted to a hospital is a question of medical judgment. And as with any judgment, whether it involves mental illness or physical illness, there is a possibility of an error. However, Appellants would emphasize that *the district court did not find that a single child had ever been admitted to a State mental health facility when hospitalization was not warranted*, and the generalizations relied upon by the Appellees and *amici curiae* do not belie this fact.[15] It also bears repeating that it is a serious error to

[15] The American Orthopsychiatric Association, et al., in their brief, evidently recognize the need to shore up this aspect of their presentation. On page 44 of that brief, *amici curiae* suggest that Appellants conceded that J.L. was hospitalized for reasons other than his own best interests as follows:

deny institutional care to a child who needs it. Appellees' implication that decreasing hospitalizations would be advantageous *per se* therefore cannot be accepted.

Turning to the "empirical studies" referred to above, most of the studies relied upon by the Appellees and *amici curiae* deal with the ability of psychiatrists to predict the future conduct and behavior of mentally ill persons. *See e.g.*, Ennis and Litwack, *Psychiatry and the Presumption of Expertise; Flipping Coins in the Courtroom*, 62 Calif. L.R. 693 (1974); Rappeport, Lasson and Gruenwald, *Evaluation and Followup of State Hospital Patients Who Had Sanity Hearings*, 118 Am. J. Psychiatry 178 (1962).

The ability of a psychiatrist to predict future behavior, such as dangerousness, is not at issue in this litigation and is not presently defended by Appellants. The challenged statute requires no such prediction, but simply a determination that a child is mentally ill and is suitable for treatment in a hospital. Thus, studies which suggest

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"The case of J.L. is illustrative. It was stipulated that this child was hospitalized because his mother was concerned that he was adversely affecting her relationship with her second husband and her child."

There is no such stipulation anywhere in the record. The stipulation to which *amici curiae* apparently refer is as follows:

"The admitting physician determined that hospitalization was appropriate because J.L. could 'not function outside the hospital and admission might be helpful'." A-68.

This stipulation makes it plain that J.L. was accepted by the hospital because he needed hospital care, and not for any other reason. *Amici curiae's* implication that J.L.'s mother coldly rejected him is refuted by the very Exhibit relied upon by *amici curiae*. In that Exhibit, J.L.'s mother was described as follows:

"She [J.L.'s mother] really cared for Joey and it was a painful, traumatic decision to give him up. It is to her credit that she dealt with the feelings of helplessness and hopelessness Joey created for her in the hope he could be put in a successful foster home." A-96.

that psychiatrists cannot predict whether mentally ill persons will commit acts of violence in the future have no relevancy at all to this case.

One study cited in the briefs of *amici curiae* does purport to deal with the ability of a psychiatrist to diagnose mental illness. That is the study conducted by Dr. David Rosenhan.[16]

Dr. Rosenhan arranged for eight persons to apply, voluntarily, to 12 different mental hospitals, with each person reporting falsely that he was hearing voices saying "empty," "hollow," and "thud." Each person was admitted. Each was subsequently discharged as being "in remission," even though none had disclosed to the hospital staff that he was faking. Each person simply reported, after his admission, that he had stopped hearing the voices. From this rather simplistic study, *amici curiae* and a great number of other persons have concluded that psychiatrists cannot correctly diagnose the presence or absence of mental illness.

Dr. Rosenhan's study has been subjected to rather severe criticism,[17] and rightly so. The most succinct comment is that the study simply proves that it is possible to trick a psychiatrist. The study has little to say about a psychiatrist's relative ability to accurately diagnose illness, for physicians attempting to diagnose physical

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[16] Rosenhan, *On Being Sane in Insane Places*, 13 Santa Clara L.R. 379 (1973). [Cited in the Brief *amici curiae* of American Orthopsychiatric Association, et al., pp. 34, 35 and the Brief *amicus curiae* of The American Bar Association, p. 22.]

[17] Dimond, *Popular Opinion is Not Empirical Data*, 2 Clin. Soc. Work J. 264-270 (1974); Kety, *From Rationalization to Reason*, 131 Am. J. Psychiatry 957 (1974); Pattison, *Social Criticism and Scientific Responsibility*, 26 J. Am. Sci. Affil. 110 (1974); Spitzer, *More on Pseudoscience and the Case for Psychiatric Diagnoses*, 33 Arch. Gen. Psychiatry 459 (1976).

illnesses must also depend upon the symptoms expressed by the patient. One commentator demonstrated the invalidity of Dr. Rosenhan's study as follows:

> "If I were to drink a quart of blood and, concealing what I had done, come to the emergency room of any hospital vomiting blood, the behavior of the staff would be quite predictable. If they labeled me and treated me as having a bleeding peptic ulcer, I doubt that I could argue convincingly that medical science does not know how to diagnose that condition." [18]

Studies frequently assist a court in arriving at its decision, and generalizations have their place in a case as important as this. However, as the foregoing review demonstrates, studies and generalizations are no substitute for the facts in the record, especially where, as here, the studies are characterized by dubious methodology and the generalizations are shown by the record to be inapplicable to the case before the Court.

D. THE QUESTION OF WHETHER THE STATE, IF IT IS TO PROVIDE SERVICES TO ITS MENTALLY ILL CITIZENS, MUST PROVIDE NEEDED MENTAL HEALTH SERVICES IN THE MOST APPROPRIATE TREATMENT SETTING, IS RIPE FOR DECISION.

Several of the *amici curiae*, including the American Orthopsychiatric Association, et al. and the United States, ask this Court not to decide the third question presented in this case. That question can be stated as follows:

> "Whether, assuming that more than one treatment setting would benefit a mentally ill person under 18 years of age, the Fourteenth Amendment to the Constitution of the United States mandates that the State must, if it is to provide services at all, provide needed mental health services in the most appropriate treatment setting commensurate with the minor's condition?"

[18] Kety, *From Rationalization to Reason*, 131 Am. J. Psychiatry 957 (1974) at p. 959.

Amici curiae American Orthopsychiatric Association, et al. argues that the matter is not ripe for one of two reasons, both of which relate to children presently in the hospital:

(1) Assuming the district court was correct, that the children were being detained unconstitutionally, there is no need to address the second issue as to their proper placement; or (2) assuming the district court was incorrect, and that there has been no unconstitutional detention, the resolution of the question of the proper placement of the children needs further evidentiary development.[19]

The brief of the United States asserts that the matter is not ripe for adjudication because it is not clear whether the district court's order that the minor be placed in "the least drastic environment necessary for treatment," was based upon the court's finding that hospitalization constitutes a violation of substantive due process, or whether the order was simply an exercise of the court's equitable power to require Appellants to remedy the effects of the initial denial of procedural due process or of unjustified continued confinement of the identified children.[20]

Amici curiae ignore the specific language found in the district court's opinion denying the stay to the Appellants in this case. There the district court said:

> "Implicit in this court's February 26, 1976 order, is

[19] Brief of American Orthopsychiatric Association, et al., pp. 10-11, note 3.
[20] Brief of the United States, pp. 33-36.

> the court's considered opinion that *every minute of unnecessary or inappropriate confinement and detention of a child in a mental hospital is a deprivation of liberty* which affects him adversely and from the harmful effects of which he may never recover. That considered judgment has not changed." A-944. [Emphasis added].

It is absolutely clear that the district court's opinion with respect to hospitalized children for whom other optimally appropriate settings could be identified was founded upon the district court's conclusion that continued hospitalization was depriving those children of their liberty in violation of the Fourteenth Amendment. That portion of the district court's order was therefore not merely remedial, but was predicated upon a separate and independent constitutional right to liberty from "unnecessary or inappropriate confinement." As such, there is no basis for concluding that this issue is not now ripe for adjudication.

CONCLUSION

For the reasons stated in the Brief of Appellants and herein, we urge the Court to reverse the judgment of the district court.

Respectfully submitted,

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CERTIFICATE OF SERVICE

I, R. DOUGLAS LACKEY, one of the attorneys for the Appellants herein, and a member of the Bar of the Supreme Court of the United States, hereby certify that I have this day served opposing counsel in this action with a copy of the foregoing Appellants' Reply Brief, by depositing same in the United States mail, with first class postage prepaid, addressed as follows:

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